

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0022608</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Village Nursing Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>9000 N. Lavergne</u> <u>Skokie</u> <u>60077</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>847-679-2322</u> Fax # () _____		Paid Preparer (Signed) <u>See Accountant's Report Attached</u> _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Mendel S. Schneider & Associates, CPA, PC.</u> <u>4556 Oakton St., Suite 200, Skokie, IL 60076</u> (Telephone) <u>847-933-1274</u> Fax # <u>847-933-1283</u>	
IDPA ID Number: <u>36-2877895</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>07/01/76</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Mendel S. Schneider</u> Telephone Number: <u>847-933-1274</u>			

STATE OF ILLINOIS

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Facility Name & ID Number Village Nursing Home# 0022608 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>98</u>	Skilled (SNF)	<u>98</u>	<u>35,770</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>51</u>	Intermediate (ICF)	<u>51</u>	<u>18,615</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>149</u>	TOTALS	<u>149</u>	<u>54,385</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>2,750</u>	<u>275</u>	<u>2,158</u>	<u>5,183</u>	8
9	SNF/PED					9
10	ICF	<u>19,615</u>	<u>4,978</u>		<u>24,593</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,365</u>	<u>5,253</u>	<u>2,158</u>	<u>29,776</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 54.75%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 07/01/76

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 18 and days of care provided 2,158Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number Village Nursing Home # 0022608 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	206,271	31,645	5,692	243,608		243,608		243,608		1
2	Food Purchase		128,400		128,400	(9,000)	119,400	(706)	118,694		2
3	Housekeeping	174,022	12,327	10,545	196,894		196,894		196,894		3
4	Laundry	51,600	3,313		54,913		54,913		54,913		4
5	Heat and Other Utilities			74,530	74,530		74,530		74,530		5
6	Maintenance	56,004		71,389	127,393		127,393		127,393		6
7	Other (specify):*										7
8	TOTAL General Services	487,897	175,685	162,156	825,738	(9,000)	816,738	(706)	816,032		8
	B. Health Care and Programs										
9	Medical Director			8,800	8,800		8,800		8,800		9
10	Nursing and Medical Records	950,788	78,379	5,228	1,034,395		1,034,395		1,034,395		10
10a	Therapy	157,382		3,928	161,310		161,310		161,310		10a
11	Activities	124,576	3,751	3,804	132,131		132,131		132,131		11
12	Social Services	21,495			21,495		21,495		21,495		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,254,241	82,130	21,760	1,358,131		1,358,131		1,358,131		16
	C. General Administration										
17	Administrative	144,832		2,400	147,232		147,232		147,232		17
18	Directors Fees										18
19	Professional Services			60,249	60,249		60,249	(34,682)	25,567		19
20	Dues, Fees, Subscriptions & Promotions			19,345	19,345	8,000	27,345	(13,981)	13,364		20
21	Clerical & General Office Expenses	111,746	20,893	38,817	171,456	(8,000)	163,456	106	163,562		21
22	Employee Benefits & Payroll Taxes			389,488	389,488	9,000	398,488		398,488		22
23	Inservice Training & Education										23
24	Travel and Seminar			355	355		355		355		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			129,941	129,941		129,941		129,941		26
27	Other (specify):*										27
28	TOTAL General Administration	256,578	20,893	640,595	918,066	9,000	927,066	(48,557)	878,509		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,998,716	278,708	824,511	3,101,935		3,101,935	(49,263)	3,052,672		29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Village Nursing Home

#0022608

Report Period Beginning:

01/01/03

Ending:

12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			18,352	18,352		18,352	(2,709)	15,643			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,074	13,074		13,074		13,074			32
33	Real Estate Taxes			9,426	9,426		9,426	236,492	245,918			33
34	Rent-Facility & Grounds			360,000	360,000		360,000	(360,000)				34
35	Rent-Equipment & Vehicles			8,369	8,369		8,369		8,369			35
36	Other (specify):*											36
37	TOTAL Ownership			409,221	409,221		409,221	(126,217)	283,004			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			81,577	81,577		81,577		81,577			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			81,577	81,577		81,577		81,577			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,998,716	278,708	1,315,309	3,592,733		3,592,733	(175,480)	3,417,253			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Village Nursing Home

0022608

Report Period Beginning: 01/01/03

Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,709)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(706)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,981)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(8,000)	20		28
29	Other-Attach Schedule ABS Management	(34,682)	19		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (52,078)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(123,402)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (123,402)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (175,480)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Village Nursing Home

ID# 0022608

Report Period Beginning: 01/01/03

Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Village Nursing Home

0022608

Report Period Beginning:

01/01/03

Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(706)	0	0	0	0	0	0	0	0	0	0	(706)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(706)	0	0	0	0	0	0	0	0	0	0	(706)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(13,981)	0	0	0	0	0	0	0	0	0	0	(13,981)	20
21	Clerical & General Office Expenses	0	106	0	0	0	0	0	0	0	0	0	106	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(13,981)	106	0	0	0	0	0	0	0	0	0	(13,875)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(14,687)	106	0	0	0	0	0	0	0	0	0	(14,581)	29

Summary B

Facility Name & ID Number	Village Nursing Home	#	0022608	Report Period Beginning:	01/01/03	Ending:	12/31/03
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Village Nursing Home# 0022608

Report Period Beginning:

01/01/03

Ending:

12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Schedule Attached		Lincoln Park Terrace, Inc.	Chicago	Lavergne Associates	Skokie	Bldg. Rental
		Alshore House, Inc.	Chicago			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 360,000	Lavergne Associates	100.00%	\$	\$ (360,000)	1
2	V	33 Real Estate Taxes				236,492	236,492	2
3	V	21 Office				106	106	3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 360,000			\$ 236,598	\$ * (123,402)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number Village Nursing Home # 0022608 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Herman Lazar	Food Supervisor		45.00		25	50.00	Salary	\$ 37,914	1--1	1
2	Herman Lazar	Sanitation Supervisor		45.00		25	50.00	Salary	37,914	6--1	2
3	Rita Brandman	Asst. Administrator				25	50.00	Salary	9,750	17-1	3
4	Rita Brandman	Housekeeping Sup.				25	50.00	Salary	9,750	3--1	4
5	Sam Brandman	Administrator		45.00		25	50.00	Salary	52,000	17-1	5
6	Pam Solomon	Admin. Consultant			87,493	5	10.00	Consultant	2,400	17-3	6
7	Sharon Schneider	Social Worker			19,958	30	75.00	Salary	21,495	12--1	7
8	Mendel Schneider	Accountant			23,100	3.5	7.50	Accounting	13,500	19-3	8
9	Mendel Schneider	Bookkeeper				1.75	3.50	Bookkeeping	3,000	19-3	9
10											10
11											11
12											12
13								TOTAL	\$ 187,723		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Village Nursing Home # 0022608 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Bank Leumi		X	Working Capital		10/15/01	200,000	275,000		7.0000	13,074		6
7													7
8													8
9	TOTAL Facility Related						\$ 200,000	\$ 275,000			\$ 13,074		9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$ 200,000	\$ 275,000			\$ 13,074		15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Village Nursing Home**# **0022608** Report Period Beginning: **01/01/03** Ending: **12/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2002 report.		\$ 231,595	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 231,726	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 131	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 236,361	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$ 9,426	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 245,918	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1998 206,060	8	
	1999 208,216	9	
	2000 214,123	10	
	2001 227,053	11	
	2002 231,726	12	
Line 4: 231726 x 1.02			

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME Village Nursing Home COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0022608

CONTACT PERSON REGARDING THIS REPORT Herman Lazar

TELEPHONE 847-679-2322 FAX # ()

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

A. Square Feet:

17,350

B. General Construction Type:

Exterior Brick

Frame 2

Number of Stories

C. Does the Operating Entity?

X

(a) Own the Facility

(b) Rent from a Related Organization.

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

X

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

X

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1983	\$ 186,189	1
2					2
3	TOTALS			\$ 186,189	3

Facility Name & ID Number Village Nursing Home

0022608

Report Period Beginning:

01/01/03

Ending:

12/31/03

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	149	1983		\$ 1,753,292	\$	15	\$	\$	\$ 1,753,292
5									
6									
7									
8									
Improvement Type**									
9	Various	1981		18,702		10			18,702
10	Roof	1982		9,669		10			9,669
11	Window Blinds	1983		2,992		10			2,992
12	Storage Shed	1983		3,364		10			3,364
13	Storage Shed	1984		9,649		15			9,649
14	Capatalized by Auditors	1980		5,225		10			5,225
15	Improvements	1986		14,289	600	19	600		12,012
16	Capatalized by Auditors	1986		4,613		10			4,613
17	Elevator	1985		33,734	1,417	18	1,417		31,583
18	Improvements	1986		7,936	333	19	333		6,388
19	Improvements	1987		3,839	120	31.5	120		2,030
20	Roof	1987		68,525	2,159	31.5	2,159		35,869
21	Wallpaper	1987		12,585	400	31.5	400		6,476
22	Improvements	1988		6,075	180	31.5	180		3,182
23	Improvements	1991		9,500	302	31.5	302		3,759
24	Windows	1992		34,473	1,094	31.5	1,094		12,537
25	Improvements	1992		6,293	200	31.5	200		2,292
26	Windows	1993		38,720	993	39	993		10,385
27	Painting & Remodeling	1995		31,945	819	39	819		6,996
28	Generator	1998		75,466	1,935	39	1,935		10,401
29	Elevator Repair	2001		32,000	821	39	821		1,881
30	Fire Alarm Repair	2001		17,518	449	39	449		1,141
31	Elevator Repair	2002		15,978	410	39	410		529
32	Remodel Reception,Lobby, Corridor,Dining Room								
33	Elevator Corridor, Nurses Station	2002		101,055	2,591	39	2,591		3,995
34									
35									
36									

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,317,437	\$ 14,823		\$ 14,823	\$	\$ 1,958,962	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 8,200	\$ 1,854	\$ 820	\$ (1,034)	10	\$ 1,860	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	497,689				10	497,689	73
74								74
75	TOTALS	\$ 505,889	\$ 1,854	\$ 820	\$ (1,034)		\$ 499,549	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Use	1994 Jeep	1994	\$ 32,106	\$ 1,675	\$	\$ (1,675)	5	\$ 32,106	76
77										77
78										78
79										79
80	TOTALS			\$ 32,106	\$ 1,675	\$	\$ (1,675)		\$ 32,106	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,041,621	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 18,352	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 15,643	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (2,709)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,490,617	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ Description:

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2001 Lexus Jeep	\$ 625.22	\$ 7,503	17
18	Facility	1999 Van	289.00	866	18
19					19
20					20
21	TOTAL		\$ 914.22	\$ 8,369	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$

13. /2005 \$

14. /2006 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

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Facility Name & ID Number Village Nursing Home

0022608

Report Period Beginning: 01/01/03

Ending:

12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/03

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 5,042	\$ 13,539	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	343,895	343,895	3
4	Supply Inventory (priced at)	1,450	1,450	4
5	Short-Term Investments			5
6	Prepaid Insurance	41,399	41,399	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	6,281	6,281	8
9	Other(specify): Due from Lavergne	54,765		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 452,832	\$ 406,564	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		186,189	13
14	Buildings, at Historical Cost		1,753,292	14
15	Leasehold Improvements, at Historical Cost	482,509	482,509	15
16	Equipment, at Historical Cost	436,178	585,178	16
17	Accumulated Depreciation (book methods)	(533,329)	(2,435,621)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 385,358	\$ 571,547	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 838,190	\$ 978,111	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 105,956	\$ 105,956	26
27	Officer's Accounts Payable	394,000	394,000	27
28	Accounts Payable-Patient Deposits	21,329	21,329	28
29	Short-Term Notes Payable	275,000	275,000	29
30	Accrued Salaries Payable	101,133	101,133	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,654	8,654	31
32	Accrued Real Estate Taxes(Sch.IX-B)		236,360	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 906,072	\$ 1,142,432	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 906,072	\$ 1,142,432	46
47	TOTAL EQUITY (page 18, line 24)	\$ (67,882)	\$ (164,321)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 838,190	\$ 978,111	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 154,706	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 154,706	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(222,588)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (222,588)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (67,882)	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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Facility Name & ID Number Village Nursing Home

0022608

Report Period Beginning: 01/01/03

Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	1	2
Revenue	Amount	
A. Inpatient Care		
1 Gross Revenue -- All Levels of Care	\$ 3,370,145	1
2 Discounts and Allowances for all Levels	()	2
3 SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,370,145	3
B. Ancillary Revenue		
4 Day Care		4
5 Other Care for Outpatients		5
6 Therapy		6
7 Oxygen		7
8 SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue		
9 Payments for Education		9
10 Other Government Grants		10
11 Nurses Aide Training Reimbursements		11
12 Gift and Coffee Shop		12
13 Barber and Beauty Care		13
14 Non-Patient Meals		14
15 Telephone, Television and Radio		15
16 Rental of Facility Space		16
17 Sale of Drugs		17
18 Sale of Supplies to Non-Patients		18
19 Laboratory		19
20 Radiology and X-Ray		20
21 Other Medical Services		21
22 Laundry		22
23 SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue		
24 Contributions		24
25 Interest and Other Investment Income***		25
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****		
27 Settlement Income (Insurance, Legal, Etc.)		27
28		28
28a		28a
29 SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,370,145	30

	2	3
Expenses	Amount	
A. Operating Expenses		
31 General Services	825,738	31
32 Health Care	1,358,131	32
33 General Administration	918,066	33
B. Capital Expense		
34 Ownership	409,221	34
C. Ancillary Expense		
35 Special Cost Centers		35
36 Provider Participation Fee	81,577	36
D. Other Expenses (specify):		
37		37
38		38
39		39
40 TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,592,733	40
41 Income before Income Taxes (line 30 minus line 40)**	(222,588)	41
42 Income Taxes		42
43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (222,588)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Village Nursing Home# 0022608Report Period Beginning: 01/01/03Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,056	2,282	\$ 66,486	\$ 29.13	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,640	14,585	343,923	23.58	3
4	Licensed Practical Nurses	2,597	2,715	62,494	23.02	4
5	Nurse Aides & Orderlies	48,252	51,491	477,885	9.28	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	6,341	6,739	157,382	23.35	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	12,426	12,965	124,576	9.61	10
11	Social Service Workers	2,080	2,102	21,495	10.23	11
12	Dietician					12
13	Food Service Supervisor	1,040	1,040	37,914	36.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,787	16,367	168,357	10.29	15
16	Dishwashers					16
17	Maintenance Workers	3,243	3,352	56,004	16.71	17
18	Housekeepers	15,358	16,230	174,022	10.72	18
19	Laundry	6,089	6,480	51,600	7.96	19
20	Administrator	4,160	4,320	135,082	31.27	20
21	Assistant Administrator	1,040	1,040	9,750	9.38	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,088	10,142	111,746	11.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	142,197	151,850	\$ 1,998,716 *	\$ 13.16	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	120	\$ 5,692	1-3	35
36	Medical Director	72	8,800	9-1	36
37	Medical Records Consultant	78	4,128	10-1	37
38	Nurse Consultant				38
39	Pharmacist Consultant	11	1,100	10-1	39
40	Physical Therapy Consultant	78	3,928	10a-1	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	96	3,804	11-1	44
45	Social Service Consultant				45
46	Other(specify) <u>Administrative</u>	120	2,400	17-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	575	\$ 29,852		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description		Amount	Description		Amount		
Sam Brandman	Administrator	45	\$ 52,000	Workers' Compensation Insurance	\$	36,609	IDPH License Fee	\$	200		
Rita Brandman	Asst. Administrator	0	9,750	Unemployment Compensation Insurance		18,635	Advertising: Employee Recruitment		2,917		
Constantine Ciceovan	Administrator	0	83,082	FICA Taxes		152,905	Health Care Worker Background Check (Indicate # of checks performed _____)				
				Employee Health Insurance		181,339	Dues-ICLTC		8,493		
				Employee Meals		9,000	Village of Skokie License		640		
				Illinois Municipal Retirement Fund (IMRF)*			Advertising		13,981		
							Misc. Inspections		1,114		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 144,832								
B. Administrative - Other											
Description			Amount								
Pam Solomon			\$ 2,400								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 2,400	TOTAL (agree to Schedule V, line 22, col.8)		\$ 398,488					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount		
Mendel S. Schneider	Accounting		\$ 16,500			\$	Out-of-State Travel	\$			
Richard Peelo	Accounting		4,200								
Frost, Ruttenberg & Rothblatt	Accounting		3,200								
Personnel Planners	U.C. Tax Consultant		817				In-State Travel				
Meyer Magence	Legal		850								
ABS Management	Jaaco		34,682								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 60,249	TOTAL		\$	Seminar Expense				
							ICLTC		355		
				</							

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

<p>Facility Name & ID Number <u>Village Nursing Home</u></p> <p>XX. GENERAL INFORMATION:</p> <p>(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>Yes</u></p> <p>(2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u> If YES, give association name and amount. <u>IL Council on Long Term Care-8493</u></p> <p>(3) Did the nursing home make political contributions or payments to a political action organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? <u>N/A</u></p> <p>(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? _____</p> <p>(5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? <u>39 Yrs</u></p> <p>(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>5,000</u> Line <u>10</u></p> <p>(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation. _____</p> <p>(8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease. <u>N/A</u></p> <p>(9) Are you presently operating under a sublease agreement? _____ YES <u>X</u> NO</p> <p>(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. _____</p> <p>(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ <u>81,577</u> This amount is to be recorded on line 42 of Schedule V.</p> <p>(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? <u>Yes-Pg 7</u> If YES, attach an explanation of the allocation. _____</p>	<p style="text-align: center;">STATE OF ILLINOIS</p> <p># <u>0022608</u> Report Period Beginning: <u>01/01/03</u> Ending: <u>12/31/03</u></p> <p>(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? <u>Yes</u></p> <p>(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? <u>No</u> For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.</p> <p>(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ <u>9,000</u> Has any meal income been offset against related costs? <u>No</u> Indicate the amount. \$ <u>0</u></p> <p>(16) Travel and Transportation a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>0</u> c. What percent of all travel expense relates to transportation of nurses and patients? <u>0</u> d. Have vehicle usage logs been maintained? <u>No</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>No</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>No</u> g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>0</u></p> <p>(17) Has an audit been performed by an independent certified public accounting firm? <u>No</u> Firm Name: <u>N/A</u> The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____</p> <p>(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u></p> <p>(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? <u>Yes</u> Attach invoices and a summary of services for all architect and appraisal fees.</p>
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